



Department of Consumer and Business Services
**Oregon Health Insurance Marketplace
Advisory Committee Meeting**

Meeting Minutes
Thursday, April 18, 2019 - 11 a.m. to 3 p.m.
Labor and Industries Building, Room 260
350 Winter St. NE, Salem, 97301

Committee members present: Kraig Anderson, Shonna Butler (by phone), Stephanie Castano, Cindy Condon, Dan Field (Chair), Mark Griffith, Jim Houser, Sean McNulty, Ken Provencher, Shanon Saldivar (Vice-chair), Cameron Smith (ex-officio), Jeremy Vandehey (ex-officio), Jenn Welander

Members excused: Joe Enlet

Other DCBS staff present: Andrew Stolfi, DFR Administrator and Oregon Insurance Commissioner; Rick Blackwell, DFR Policy Manager

Marketplace:

Chiqui Flowers, Administrator; Anthony Behrens, Senior Policy Advisor and Carrier Liaison, Elizabeth Cronen, Legislative and Communications Manager; Cable Hogue, Implementation Analyst and Federal Liaison; Victor Garcia, Operations Development Specialist; Dawn Shaw, Division Support Coordinator

Agenda item and time stamp*	Discussion
Welcome and introductions, committee housekeeping 0:0:00*	The committee agreed to review and approve the meeting minutes from January 24, 2019 before the end of the meeting to give members a chance to review. Introduced Dawn Shaw, taking over as Marketplace Advisory Committee liaison from Victor Garcia.
Marketplace Advisory Committee annual report 0:03:43	Elizabeth Cronen discussed the final draft of the Marketplace Advisory Committee annual report. <ul style="list-style-type: none">• The draft report is called for in the established legislation and is separate from the Marketplace annual report. Most of the report is required in statute; the data is not readily available (i.e. financial health, enrollment data).• The most flexible section is feedback from the community about satisfaction with the operation of the exchange and qualified health plans offered through the exchange.• Used previous meetings to capture the committee's thoughts for this section.• Two themes emerged from the previous meetings: affordability of the plans for consumers and feedback about technology.• In regards to reducing premiums, the one cost component that the Marketplace has the most control of are the fees that go to the federal government for HealthCare.gov.• The committee appeared to have a clear recommendation to explore other options for state-based technology and an RFI (request for information) made sense. Elizabeth requested feedback to make sure that impression was correct and was accurate in the report (pages 8-10).• Cindy Condon had some feedback that may not have been captured and Elizabeth will schedule a meeting to go over her concerns. Cindy wanted to ensure the report took into account the consumers' complaints.

- It was the feeling that the exercise that was done was focused on technology. Technology appears to be a bottleneck and something that this committee has control over.
- Must be value driven and capture not only the technology but on how it will help consumers.
- The report may want to add in things that were discussed and may require further discussion. Will help with future committee members.
- There is some confusion between the Marketplace agency report (due by April 15) and the MAC annual report (no deadline). There is about a 70% overlap. Both reports are in statute. The agency report helps populate the MAC report, which future versions could be framed as a response to the agency report.
- Elizabeth will add in additional feedback and get the final draft out.
- May want to put information in the cover letter for the MAC report to refer to the Marketplace agency report so they are aware of why they received similar reports.

Federal health policy movement

0:35:20

Stephanie Kennan from McGuireWoods Consulting called in from Washington D.C. to present information about current legislation and cases that involve the Affordable Care Act (ACA).

- Energy and Commerce Committee did a double mark up with six bills related to drug pricing and the ACA. The drug pricing side went through very bipartisan, then it got to the ACA and it was not. There was only one bill that passed on Boy Scout, to be discussed later.
 - State Allowance for Variety of Exchanges (a.k.a. SAVE Act, HR 1385) was bipartisan with a final vote of 29-22. Provides states with \$200 million in federal funds to establish State Based Marketplaces. Currently under federal law, states are no longer able to use federal funds to create a Marketplace. Designed to help set up, but not transition from one platform to another.
 - Expand Navigators Resources for Outreach, Learning and Longevity Act (a.k.a. the Enroll Act, HR 7102) passed by a vote of 30-22. Would provide \$100 million annually for Federally Facilitated Marketplaces Navigator programs. Would reinstate the requirement for two navigator entities in each state and HHS to ensure the Navigator grant is awarded to entities that demonstrate the ability to carry out their duties. Would also prohibit HHS from considering if the entities have demonstrated how well it would provide information related to specific health plans or short-term plans.
 - Marketing and Outreach Restoration to Empower Health Education Act (a.k.a. the MORE Health Education Act, HR 987). Would restore money taken out of the program for outreach and education to assist consumers with signing up for health care through the Exchange.
 - HR 1010 overrides the Trump administrations short-term and limited duration insurance plans. It was very partisan.
 - Pre-existing Conditions Protection Act of 2019 (HR 692), passed. Would require that the Trump administration to rescind the section 1332 guidance for the ACA that was put out October 2018 that undermines the consumer protection.
 - State Health Care Premium Reduction Act (HR 1425) would provide \$10 billion to establish state reinsurance programs or use the funds to provide financial assistance to reduce out-of-pocket costs for

- individuals enrolled in qualified plans. Requires CMS to establish a reinsurance program for states who do not apply for federal funding under the bill.
- Republicans were fairly adamant that Navigators or money to assist consumers should also be used for short-term and limited duration plans.
 - Energy and Commerce was the only committee so far that has acted on any ACA-related bills, Ways and Means has not. A third committee is resurrecting its role in health reform, Education and Workforce, and is trying to claim jurisdiction on the ACA.
 - Do not have a timeline for when the bills will hit the floor. It is clear that drug pricing issues will come first and one that everyone can agree on.
- Mr. Grassly, Chairman of the Senate Finance Committee has said he would only deal with issues that have bipartisan support. He does not appear to want to reopen ACA issues, which is a stumbling block to making any improvement on the ACA.
 - At the end of March, the Associated Health Plans case finally got a ruling and the judge ruled in favor of the Democratic AG.
 - Twenty-four Republican Senators introduced a bill that codifies the administration's final rule on Associated Health Plans right before they left town.
 - Bernie Sanders has the Medicare for All, Elizabeth Warren dropped a bill that is ACA related. Other presidential candidates are also backing both.
 - Senator Cain from Virginia and Senator Bennett from Colorado, both presidential candidates, put in their Medicare Acts Bill. The Medicare Acts Bill would allow people to purchase a public plan on the Exchange and allow for tax credits up to 400% of the FPL. It would remove the cap to allow people who make more money to get the tax credit if they apply for a private plan or one through the Medicare Act plan.
 - Court cases and their status
 - Texas v. Azar – they are scheduling oral arguments that should be between July 9 – 12. Briefs from the administration are due May 1 and response from the defendant due May 22. Fifth Circuit cases average 10 months per case. It will be awhile before the Supreme Court will decide if they want to take the case.
 - Columbus et al v. Trump (a.k.a Take Care Case) – Cities of Columbus, Baltimore, Cincinnati, Chicago, Philadelphia, and two citizens filed a case because they feel that the Trump administration is violating the Constitution because they are not faithfully executing the law. On March 8, the DOJ asked for a dismissal of the lawsuit along with a declaration from a senior HHS Director stating they are following the law. The declaration focused on rate setting for 2019 as evidence. The judge gave the plaintiffs until May 1 to respond.
 - Franciscan Alliance v. Azar (Transgender abortion case) – was quiet for about 17 months. Judge O'Connor (same as Texas v. Azar) lifted the stay and set a briefing schedule to conclude on May 24. May set up a schedule a hearing and a rule on the motion to intervene, but so far has just set the briefing schedule.
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- Health Insurance Tax for Medicaid Managed Care Organizations, (another one with Judge O'Connor) -- ordered the parties to produce information in order to calculate the HIT for 2014-2016 by April 5. If they fail to do so, he would schedule a bench trial for June 10. No word if the information has been produced, but no word on the bench trial. Continuing to monitor the situation.
- Subsidy case – on March 8 it was announced that insurers will have to wait a few more months for missed 2018 cost sharing reduction payments. The judge asked the federal government to hold off until CMS has a chance to verify the amount they should have received had the administration not cut off the payments. There is a deadline of March 22 to see if she will award over \$100 million for missed 2017 CSR payments.
- Associated Health Plans case -- the judge struck down the administrations rule stating that they did an end run around the ACA. It is unknown if they will appeal the decision.

2019 Open enrollment data analysis

0:56:26

Cable Hogue presented information regarding enrollment data for 2019 open enrollment

- Based on the public use data that was released by CMS the last week of March. Previously hinted about but was not publicly able to share. Compared last year's to this year's numbers and trends in the presentation.
- First slide is the overall enrollment status and total plan selection.
 - This year we had 148,180, a 5% decline from the previous open enrollment due to fewer new consumers. There is about a 21% decrease in new consumers coming to the Marketplace. Can be because of more people having insurance through employers.
 - Total re-enrollees increased by 2%, active re-enrollees about the same and an increase in the auto re-enrollees.
 - Active re-enrollees that switched plans not as large as the active re-enrollees. They will look at the other plans and decide to remain with their current plan.
 - Decrease in people who switched plans, from 38,789 to 36,176, a 7% decrease.
 - Active re-enrollees on the same plan or crosswalked (their plan was discontinued) to a new plan increased by 7%. If someone is crosswalked, our Plan Management Analyst does make sure that the plan they are crosswalked to is similar to the plan they had. Includes changes from one insurer to another or changing tiers in the same company.
 - Has not had an opportunity to compare to 2017 data but will get that information together and send it out. May only be able to go back to 2016 because of the change from Cover Oregon to the federal platform. For the first few years on the federal platform, some data may not have been tracked so might not line up with current data.
 - The annual report has the county breakdown of the enrollment data.
 - Questions about stability and if there is data that shows if there is a trend of enrollees going from one plan to another. We may not have that data.
 - Do not have information on why people moved from plan to plan or tier to tier. CMS is hesitant to document that information.
 - It is preferable to have people go in and shop for plans.

- No information on what plan enrollees had before and why they left the plans.
- Stability may not exist in people's lives due to moving, change of employment, and other financial responsibilities.
- Concern that the lack of a penalty will affect the enrollment for 2020.
- This year we saw 140,378 effectuate, a 95% conversion rate, which is the highest conversion rate we have had since joining HealthCare.gov. As the year goes on, the effectuation rate shrinks. Effectuation is the amount of people who paid premiums.
- APTC/CSR data: average premium went up by 6%, average premium after APTC went up 4%, consumers with APTC went down 6%, average consumers receiving APTC went up 8%, 1% increase of the average premium after APTC for those receiving APTC, consumers with CSR went down 8%, and an increase of 4% for tribal enrollment.
- There has been an increase in group insurance due to large group and self insured, small group has remained relatively level, and the individual market has decreased. The number of uninsured has stayed about the same. Hard to get some data because we don't know why consumers are leaving plans.
- Enrollment by age: <18 10% decrease, 18-25 9% increase, 26-34 7% decrease, 35-44 10% increase, 45-54 5% decrease, 55-64 4% decrease, and 65 and over had a 4% increase.
- Enrollment by demographic: male 6% decrease, female 4% decrease, AI/AN 2% increase, Asian 1% increase, Native Hawaiian/Pacific Islander 10% increase (probably due to COFA and most accurate), African-American 1% decrease, White 2% increase, other 8% decrease, multiracial 5% increase, other 26% decrease, Hispanic/Latino 1% increase, and not Hispanic/Latino 3% increase.
- Enrollment by FPL: 2% decrease in those not requesting financial assistance, 100%-150% FPL 6% decrease, 150%-200% PFL 9% decrease, 200%-250% 8% decrease, 250%-300% 6% decrease, 300%-400% 1% increase, and other FPL 3% decrease.
- Enrollment by metal tier: Catastrophic 175% increase, Bronze 2% decrease, Silver 10% decrease, and Gold 6% increase. In some cases the gold plans are cheaper than silver. Increase in the catastrophic plans were due to first dollar coverage that bronze plans did not have.
- Getting a state-based system would make it easier to get more reliable data. We get some high level numbers, but we can't dictate the script on what the call center can ask.

2019 Marketplace request for information

1:54:56

Victor Garcia presented information on the 2019 RFI process for a state-based marketplace (SBM) and consumer assistance center.

- Marketplace staff have been analyzing the information for awhile. Internally talked to IT and to OHA to make sure any OHP questions were answered by them.
- On April 5, 2019, the RFI was released on ORPIN, the state procurement website.
- Deadline for vendors to submit questions is April 19, 2019. We haven't really gotten a whole lot so far. Most likely due to vendors knowing we were interested in talking about getting an SBM system. They have already done them for

Nevada and New Mexico so they have a good idea about what states are looking for.

- May 3, 2019 is the deadline for Marketplace to post the answers to the questions.
- May 31, 2019 is the submission deadline and the RFI will close.
- Next steps
 - Make a summary of the responses and present them in the next MAC meeting to make discussions and recommendations.
 - Other path forward items that can be done while the summary and presentations are occurring is a development of the business case.
 - There is a specific process that needs to occur with any software through the state OSCIO, an independent entity in DAS.
 - Need to do a business analysis on what we look like now and what it will likely look after a switch. This will happen after the RFI closes and we have the MAC recommendations. Will need to look at what we are doing and eliminating redundancy. What the budget and cost analysis are and how many people we will need. Will need to look at the gap analysis on what we will need to get there from here.
 - OSCIO Stage Gate requirements emphasize planning thoroughness and details. We will need to update them as we go.
 - A lot of moving parts to make sure we are following all the requirements. ESO (Enterprise Security Office) to make sure we are complying with all security requirements, DAS Procurement Services to make sure we are complying with procurement rules, DOJ for contract and RFP legal review, and LFO for legislative budget review.
 - Will need to engage an outside vendor(s) for quality assurance for the RFP and overall project.
 - We will need to look to see if there is a product that already exists that will work with OHA and HealthCare.gov.
 - Our current vendor is HealthCare.gov and we are looking to have an apples-to-apples comparison with a new vendor.
 - Concern by carriers discussed, mostly RFI vs. RFP.
 - Question about the timeline. We are looking at least two to three years. CMS does not appear to have had issues with the other states who have gone through this process.

2019 Oregon legislative session

2:18:42

Elizabeth Cronen and Anthony Behrens reviewed the 2019 Oregon legislative session.

- HB 5011 – DCBS budget bill. Confident it will pass, it is in the Joint Ways and Means. Other Fund agencies, who get funds from fees or other revenues, typically gets reviewed before General Fund agencies, which get money from the state (taxes). COFA has a little bit of general funds.
 - HB 2269 – one piece of four parts of Governor Brown’s budget package to help fund the Oregon Health Plan. Is for employers with 50 or more employees to require a minimum amount paid for employee health care. They can either directly spend or they can contribute to a healthcare access fund that would help support the OHP and provide additional subsidies.
 - SB 770 – Establishes the Universal Health Care Commission. They would be tasked with creating Health Care for All Oregon. The first meeting will be in November 2019. An interim report is due March 15, 2020, a final report no later
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than February 1, 2021. It is in Joint Ways and Means and has a Do Pass recommendation.

- HB 2012 – Medicaid Buy-In bill amended to create a study to get to the 6% of Oregonians that are uninsured. It may be amended to go up to 600% of FPL. In Joint Ways and Means with a Do Pass. OHA is tasked with coming up with the plan.
- HB 2706 – would establish a COFA dental program. Would be administered by OHA in cooperation of the Marketplace. We may need some additional staff to assist with that process. In Ways and Means with a Do Pass. There is some discussion on whether it should be similar to the OHP Dental or are there other factors to consider. There needs to be a study to determine needs and costs.
- SB 250 – passed Senate 25-4. DFR’s ACA reconnect bill.
- SB 735 – adds members to the Health Plan Quality Metrics Committee and directs them to work with PEBB, OEBC, and DCBS to adopt measures of health outcomes and health care quality. Look at in-patient and outpatient services provided by hospitals. Now will look at health care paid by benefit plans and not just QHPs.
- SB 889 – There was an interim task force in 2017 that looked at Maryland’s hospital rate setting and other cost drivers. Determined that Maryland’s plan would not work for Oregon. Recommended that we adopt a program similar to Massachusetts that has a statewide total cost-of-care spending target. Oregon is already are doing it with CCOs and will expand it across all markets. It is in Ways and Means to create an implementation group.
- HB 2226 – requires OPHB to study changes in insurance coverage since the implementation of the ACA. Report to the legislature in 2021. Sent to rules without recommendation.

DFR panel

Rick Blackwell and Andrew Stolfi discussed 2019 rates and processes, consumer advocacy initiatives, and legislative priorities.

2:50:35

- Individual and small group timeframes for the 2020 rate review process. May 13 is the filing deadline. It usually takes a day or two to have everything posted online. By the May 28 will announce the hearing schedule. There will be an optional public conference call on June 10 or 11 to explain the filings that have come in. June 21 is the public preliminary decision date, usually similar to the final decision. July 2 and 3 there will be public hearings and the final public comment period will end on July 3. Proposed final decision will be on or around July 15 with final rates posted August 15. There is a proposal to streamline the process and make it more consumer friendly. Have not heard anything yet on any major changes, like withdrawing from the areas or large rate increases.
- HB 2703 follow up – proposal on behalf of OAHU, short-term plans are limited to two months and cannot be renewed for sixty days. The intent was to give people coverage outside of SEPs QHP availability. Did not make it out of committee. The bill didn’t pass but the committee discussed circumstances where people would be without insurance if for example they didn’t update their autopay or failed to make a premium payment. Went over all the situations, discussed what could be done to help avoid these situations. Put it into two buckets, things that we can get consensus on now and what we could focus on later.
- Consumer marketing and outreach campaign that started earlier this year. Promotes what we are and what we do. TV, radio, and print in English and Spanish. TV ads already on auto accident and debt management are

running now, another ad about health insurance will be running soon. Had a half million budget and have worked with Comms to save money on production and social media.

- On June 7, we are going to have a symposium at the Salem Convention Center. You are all welcome to attend.
- Legislative priorities and updates.
 - Key dates, March 29 was the last day for work sessions hosted by a policy committee.
 - April 9 is the last day to hold the work sessions.
 - Many bills died or went to another committee.
 - All of the DFR bills are out of the three chambers.
 - SB 250A – 25-5 passed and 4/1 in committee
 - Looking at connecting Oregon insurance code to the Affordable Care Act. Making sure it is clear on pre-existing conditions, guaranteed issue/renewability. Making sure to align the non-discrimination provisions of section 1557 of the ACA. Clarifying which health plans need to cover mental health parity. We will have the ability to set up risk adjustment program
 - SB 249A – prior authorization reform. Passed 29-0. Trying to make sure there are clear timelines. Worked in the unlawful business practices around claims settlements.
 - HB 3074A – reduce the amount of administrative orders drafted in the rate review process. Passed 48-8 with 4 excused. Does not remove transparency. Asked for flexibility around modifying a rate order. Making sure that the terms aligned with current terminology.
- Elizabeth Cronen asked a question about rates and that the public may find useful is to make sure that the public is more aware that the letters that are sent out could include the APTC. Some consumers cancel because they see the straight increase.

Closing

Shanon Saldivar wanted to discuss bronze plans coming out in 2020 that include copays for primary care, specialists, behavioral health, and prescription drugs. She is very excited about this.

Proposed to have the next meeting July 17 instead of June 6 so we can have information about legislative wrap up and the RFI to report out.

Voted and approved the January 24 minutes.

*These minutes include timestamps from the meeting audio in an hours: minutes: seconds format. The meeting audio can be found on the advisory committee web page (link below) under 2019 Meetings, April 18.

** Meeting materials are found on the Oregon Health Insurance Marketplace Advisory Committee website: healthcare.oregon.gov/marketplace/gov/Pages/him-committee.aspx